TRICARE Fundamentals Course

TRICARE Options

2

Participant Guide

References

10 USC
32 CFR § 199
TRICARE Policy Manual, Chapter 10
TRICARE Reimbursement Manual, Chapter 1
TRICARE Operations Manual, Chapter 6

Brainteasers

Each of the 8 items below is a separate puzzle.

How many can you figure out?

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5.  	6. MAN BOARD	7. SSSSSSSSSSE	8. $0 all all all all

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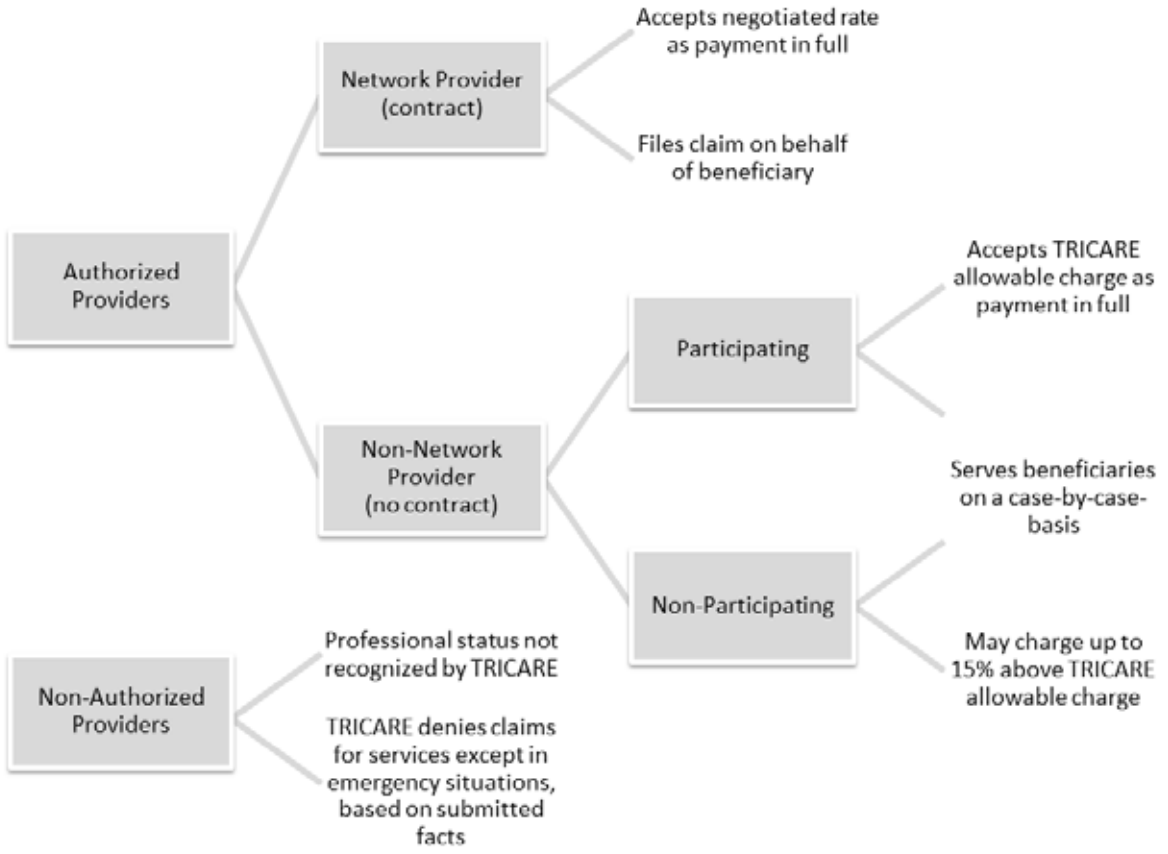
Module Objectives

- **Explain the differences between TRICARE Standard, Extra, and Prime**
- **Identify TRICARE-authorized provider types**
- **Explain the TRICARE costs associated with the basic TRICARE options**
- **Describe the TRICARE Prime Travel Benefit and the reimbursement process**



1.0 TRICARE Provider Types

TRICARE beneficiaries may receive care from the following provider types:

1.1 Authorized Provider

An authorized provider is any individual, institution/organization, or supplier that is licensed by the state, accredited by a national organization, or meets other standards of the medical community and is certified to provide benefits under TRICARE. Regional contractors must verify a provider's authorized status before they pay any portion of a provider's bill.

1.2 Subsets of Authorized Providers

Network Provider

A network provider is an individual, institution, or organization serving TRICARE beneficiaries through a contractual agreement with the regional contractor.

Non-Network Provider

A non-network provider has no contractual agreement with the regional contractor.

- *Non-Network Participating Provider*: A non-network provider who participates or accepts the TRICARE allowable charge.

- *Non-Network Non-Participating Provider:* a non-network, authorized provider who does not accept the TRICARE allowable charge as payment in full for covered services.
    - A non-participating provider may "balance bill" a beneficiary for the difference between the TRICARE allowable charge and the provider's billed charge; however U.S. Federal law prohibits the beneficiary from being legally responsible for billed charges 15 percent or more above the TRICARE allowable charge (115 percent of the TRICARE allowable charge) for TRICARE-covered services.
    - Participating and non-participating providers may require payment up front.
- Before getting care, beneficiaries should ask providers if they are TRICARE-authorized network or participating providers as these are less costly options for the beneficiary.

1.3 Non-Authorized Provider

A non-authorized provider is a provider whose professional status is not recognized by TRICARE. Providers may be non-authorized because they do not meet state licensing or training requirements, didn't seek to or declined to treat TRICARE-eligible beneficiaries, or are not in a provider class recognized by TRICARE (they provide care outside TRICARE's benefit structure (e.g., acupuncture.)

- TRICARE denies claims from non-authorized providers, except in emergency situations, based on submitted facts.
- It is the beneficiary's responsibility to know whether a provider is TRICARE-authorized.
- If beneficiaries ask if their provider can become an authorized provider, refer them to: tricare.mil/providers, or the regional contractor.

Note: Provider directories are always subject to change. Beneficiaries should check with the regional contractor to locate network providers and call the provider's office to validate the provider's status. A listing in the directory does not guarantee the provider's information is current or that a provider is accepting new patients.

2.0 Standards and Types of Care

"Access to care refers" to established standards for accessing care in a timely manner and within a reasonable distance for all TRICARE Prime enrollees.

	Urgent Care	Routine Care	Referred/Specialty	Wellness/Preventive
Appt. Wait Time	Within 24 hours	Within 7 days	28 calendar days (4 weeks)	28 calendar days (4 weeks)
Drive Time	Within 30 min. of beneficiary's home	Within 30 min. of beneficiary's home	Within 60 min. of beneficiary's home	Within 30 min. of beneficiary's home
Wait Time in Office	Not to exceed 30 minutes for non-emergency situations			

Emergency Care

Emergency care refers to medical, maternity, or psychiatric emergencies that would lead a "prudent layperson" (someone with average knowledge of health and medicine) to believe that a serious medical condition exists, or the absence of medical attention would result in a threat to life, limb, or eyesight and requires immediate medical treatment, or the condition is so painful that sedative treatment is required to relieve suffering.

Urgent Care

Urgent care is generally defined as non-emergency acute illness or injury which requires medically necessary treatment, but would not result in disability or death if not treated immediately. This kind of illness or injury does require professional attention and should be treated within 24 hours to avoid further complications.

Routine Care

Routine care, also known as primary care, includes general office visits for the treatment of symptoms, chronic or acute illnesses and diseases, and follow-up care for an ongoing medical condition. The primary care manager (PCM) should be the primary source of all routine care.

Wellness and Preventive Care

Wellness and preventive care includes services, such as health screenings and examinations, often conducted at regular intervals, which are meant to keep beneficiaries healthy or detect health problems in a timely manner (e.g., mammograms, pap smears, cholesterol testing).

Specialty Care

Specialty care is generally defined as care the PCM is not able to provide.

3.0 TRICARE Options

TRICARE Standard is a fee-for-service option.

- The beneficiary may seek care from any TRICARE-authorized provider
- No enrollment required
- Larger pool of providers

TRICARE Extra is a preferred provider option (PPO) in which Standard beneficiaries use TRICARE network providers.

- No enrollment required
- Five percent discount off the TRICARE Standard cost share
- No claims to file (the provider files for the beneficiary)

TRICARE Prime is a managed care option similar to a civilian health maintenance organization (HMO), in which health care is managed by a primary care manager.

- Enrollment required; based on location
- No deductibles for health care
- Highest priority for access to care if enrolled to the MTF

The next sections describe these programs and associated costs.

4.0 TRICARE Standard

TRICARE Standard is a fee-for-service option where the beneficiary has the freedom to choose from a larger provider pool without having to get prior authorization for most TRICARE-covered medical services. TRICARE Standard is available worldwide.

4.1 Eligibility

- Available for all non-active duty TRICARE-eligible beneficiaries.
- Beneficiaries present a valid Uniformed Services ID card as proof of eligibility.

4.2 Enrollment

No enrollment forms or fees.

4.3 Billed Charge

A billed charge is the provider's proposed total cost without any discounts or reduced fees.

4.4 TRICARE Allowable Charge

The TRICARE allowable charge is the maximum amount TRICARE pays for services. By law, it is tied to Medicare's reimbursement rates when practical. The TRICARE allowable charge is "locality based," meaning it varies depending on the location of care.

4.5 Deductible

The annual amount a TRICARE Standard/Extra beneficiary pays for covered outpatient benefits before TRICARE begins to share costs.

4.6 Cost Share

The percentage of the allowable charge beneficiaries pay under TRICARE Standard, TRICARE Overseas Program Standard, and Standard like options, TRICARE Overseas Program Standard, TRICARE Reserve Select, TRICARE Retired Reserve, and TRICARE Young Adult. The cost share depends on the sponsor's status (e.g., active duty, retired).

4.7 Balance Billing Limitation

- A non-network non-participating provider may choose not to participate or "accept assignment."
- Under federal law, these providers may not bill more than 15 percent above the TRICARE allowable charge for covered services, unless the beneficiary agrees and signs to pay higher amount.
- Beneficiaries should wait for their explanation of benefits (EOB) before paying additional money to non-participating providers or follow up with the provider or regional contractor in case they overpaid.

4.8 Catastrophic Cap

The catastrophic cap is the maximum amount a beneficiary pays out-of-pocket for TRICARE-covered services or supplies per fiscal year.

- Payments counted toward a TRICARE Standard catastrophic cap include:
  - Deductibles
  - Cost shares
  - Prescription copayments
- Payments that do not count toward a beneficiary's catastrophic cap include:
  - Payments for balance billing (More than 15% above the TRICARE allowable charge if the beneficiary agreed to pay this amount)
  - Out-of-pocket payments for services not covered by TRICARE.

4.9 TRICARE Standard Costs

Status	ADFM E1–E4	ADFM E5 and Up	Retirees, Retiree Family Members, and Survivors
Enrollment Fee	N/A	N/A	N/A
Deductibles	$50 individual $100 family	$150 individual $300 family	$150 individual $300 family
Cost Shares	20% of TRICARE allowable charge	20% of TRICARE allowable charge	25% of TRICARE allowable charge
Catastrophic Cap	$1,000 per family per fiscal year	$1,000 per family per fiscal year	$3,000 per family per fiscal year
Civilian Inpatient Cost Share	Per diem or $25 per admission, whichever is greater; no charge for separately billed professional charges	Per diem or $25 per admission, whichever is greater; no charge for separately billed professional charges	Per diem or 25% of the total charge, whichever is less, plus 25% of the TRICARE allowable charge for separately billed professional services
Civilian Inpatient Mental Health	Per diem or $25 per admission, whichever is greater	Per diem or $25 per admission, whichever is greater	**High Volume Hospitals:** 25% of hospital specific charges **Low Volume Hospitals:** $202 per day or 25% of the billed charges, whichever is less **Partial Hospitalization:** 25% of the TRICARE allowable charge, plus 25% of the TRICARE allowable charge for separately billed professional services

Note: Costs are subject to change each fiscal year. Beneficiaries are responsible for paying the annual outpatient deductible and applicable cost shares. The government shares the cost for TRICARE-covered services after the outpatient annual deductible is met. Deductibles and cost shares count towards the catastrophic cap. Actual per diem costs vary for groups listed above.

4.9.1 Balance Billing Example

A TRICARE Standard E-5 active duty family member (ADFM) visits a non-network provider for an outpatient cardiology consult appointment. The cardiologist does "not participate" or accept the TRICARE allowable charge as payment in full. The provider usually charges $1,000 for this type of appointment. TRICARE's allowable charge is $850. Remember, the provider may bill the beneficiary for an additional 15 percent over the TRICARE allowable charge.

4.9.2 Balance Billing Illustration:

Provider Billing	**Cost**
Amount charged by the provider for cardiology appointment	$1,000.00
TRICARE Allowable Charge	$850.00
Additional 15% the provider is allowed to bill per federal law	$127.50 (15% of $850)
Total amount the provider can legally bill for services rendered	$977.50 ($850.00 + $127.50)
Settling the Payment with the Provider	
TRICARE Allowable Charge	$850.00
Beneficiary pays annual deductible	$150.00
Remaining Balance	$700.00
TRICARE Payment	$560.00 (80% of the remaining balance)
Beneficiary's Cost Share	$140.00 (20% of the remaining balance)
Beneficiary's total out-of-pocket cost to cover	$417.50 ($150.00 + $140.00 + $127.50)

Note: Although the total amount charged is $1,000.00, the beneficiary is not responsible for paying more than 15% of the TRICARE allowable charge. Under federal law, the provider can not legally hold the beneficiary responsible for the total amount of the visit.

4.9.3 TRICARE Standard Exercise

Mrs. Green, an ADFM, and her three children moved in with Grandma in a non-network area while her husband (sponsor), an E-4, is deployed.

Mrs. Green had a routine check-up with her new family physician who is a TRICARE participating provider. This was the first outpatient visit of the fiscal year for the Green family. Mrs. Green's first visit cost $50 (TRICARE allowable charge).

She had one follow-up visit, which was $40 (TRICARE allowable charge). In between her two doctor visits, her three children were seen by the same provider for routine appointments. Each of their visits cost $40 (TRICARE allowable charge).

	How much was charged per visit?	How much of each charge was applied to the annual outpatient deductible?	How much was Mrs. Green's cost share percentage and what was the dollar amount she paid per visit?
Mrs. Green's First Visit			
Child #1's Visit			
Child #2's Visit			
Child #3's Visit			
Mrs. Green's Follow-Up Visit			

5.0 TRICARE Extra

When a TRICARE Standard beneficiary receives care from a network provider, the beneficiary is using the TRICARE Extra option. Beneficiaries get a 5% cost share discount.

5.1 Eligibility

Available to only stateside TRICARE Standard beneficiaries. TRICARE Extra is **not** available overseas, including U.S. Territories.

5.2 Enrollment

No enrollment fees or forms.

5.3 Using TRICARE Extra-Must Receive Care from a Network Provider

Like Standard, beneficiaries present their Uniformed Services ID card to the network provider to receive care. The network provider accepts the regional contractor's negotiated rate as payment in full for services rendered and agrees to file the claim for the beneficiary.

5.4 TRICARE Extra Costs

Status	ADFM E1–E4	ADFM E5 and Up	Retirees, Retiree Family Members, and Survivors
Enrollment Fee	$0	$0	$0
Deductibles	$50 individual $100 family	$150 individual $300 family	$150 individual $300 family
Cost Shares	15% of fee negotiated by regional contractor	15% of fee negotiated by regional contractor	20% of fee negotiated by regional contractor
Catastrophic Cap	$1,000 per family per fiscal year	$1,000 per family per fiscal year	$3,000 per family per fiscal year
Civilian Inpatient Cost Share	Per diem or $25 per admission, whichever is greater; no charge for separately billed professional charges	Per diem or $25 per admission, whichever is greater; no charge for separately billed professional charges	$250 per day or 25% of the total charge, whichever is less, plus 20% of the TRICARE allowable charge for separately billed professional services
Civilian Inpatient Mental Health	Per diem or $25 per admission, whichever is greater	Per diem or $25 per admission, whichever is greater	20% of total charge, plus 20% of the TRICARE allowable charge for separately billed professional services

Note: These costs are subject to change each fiscal year. Beneficiaries are responsible for paying the annual outpatient deductible and applicable cost shares. The Government shares the cost for TRICARE-covered services after the outpatient annual deductible is met. Deductibles and cost shares are counted toward the catastrophic cap. Actual per diem costs vary for the groups listed above.

5.5 TRICARE Extra Exercise

Mrs. Green, an ADFM, and her three children are TRICARE Standard. They moved in with Grandma within 10 miles from a military installation while her husband (sponsor), an E-5, is deployed.

Mrs. Green had a routine check-up with her new family physician who is a TRICARE network provider. This was the first outpatient visit of the fiscal year for the Green family.

Mrs. Green's first visit cost $100. She had one follow-up visit that cost $75. In between her two doctor visits, her three children were seen by the same provider for routine appointments. Each of their visits cost $75.00.

	How much was charged per visit?	How much of each charge was applied to the annual outpatient deductible?	How much was Mrs. Green's cost share percentage and what was the dollar amount she paid per visit?
Mrs. Green's First Visit			
Child #1's Visit			
Child #2's Visit			
Child #3's Visit			
Mrs. Green's Follow-Up Doctor's Visit			

6.0 TRICARE Prime

TRICARE Prime is a managed care option similar to a civilian health maintenance organization. TRICARE Prime is available in established Prime Service Areas, including overseas. For more information about TRICARE Overseas Program (TOP) Prime, see the *TRICARE Overseas* module.

6.1 Eligibility

- Active duty service members
- Active duty family members
- Transitional survivors
- Certain unremarried former spouses
- Retirees, retiree family members, survivors (stateside only)
- Certain Guard and Reserve members and their eligible family members when the sponsor is called or ordered to active duty for more than 30 consecutive days under written federal orders and funding or is issued delayed-effective date active duty orders to serve for more than 30 consecutive days in support of a contingency operation (also known as "early eligibility").
- Medal of Honor recipients and their eligible family members.

6.2 Enrollment

- Beneficiaries must submit a completed TRICARE Prime enrollment form.
- Enrollment is open year-round.

6.2.1 Enrollment Process

- Eligible beneficiaries must be registered in DEERS and submit a *TRICARE Prime Enrollment Application* (DD Form 2876).
- Beneficiaries may get enrollment forms from the TRICARE Service Center (TSC) or via the TRICARE web site at tricare.mil/forms.
- Prime-eligible beneficiaries may enroll online at the Beneficiary Web Enrollment (BWE) web site at dmdc.osd.mil/appj/bwe (not available FY 2012 for those who pay an enrollment fee due to fee changes).
- Beneficiaries should submit enrollment forms, along with the enrollment fee (if applicable), to the closest TRICARE Service Center (TSC) or mail it to their regional contractor.
    - The enrollment form and fee must be received by the 20th of the month for coverage to begin on the first day of the following month.
    - If received after the 20th of the month, Prime coverage begins for on the first day of the second month.
    - The 20th of the month rule does not apply to active duty service members (ADSMs).
- Eligible beneficiaries, other than ADSMs, remain covered under TRICARE Standard/Extra until TRICARE Prime coverage begins.

6.2.2 Enrollment Fees

- Active duty and ADFMs do not pay enrollment fees.
- All other Prime-enrollees pay an annual enrollment fee of $260 per individual and $520 per family if enrolled after October 1, 2011.
    - If enrolled prior to October 1, 2011, the annual enrollment fee remains at $230 per individual and $460 per family for FY 2012.
    - An initial three-month payment must accompany the completed enrollment form.
    - Fees may be paid annually, quarterly, or monthly.
    - Payment of enrollment fees may be made on an annual or quarterly basis. Acceptable forms of payment are by credit card, Electronic Fund Transfers (EFTs), and allotment from retirement pay.
    - Recommend to beneficiaries turning 65 that they make quarterly payments, monthly allotments, or EFT payments so that they can stop payments when they become Medicare entitled.
    - EFTs: Beneficiaries make arrangements through their financial institution (bank, credit union, etc.).
    - Allotments: Qualified enrollees set up automatic monthly payments then their retiree pay can be established through the regional contractor or directly through uniformed service finance centers.
- Enrollment is for a fiscal year; enrollment fee payments are calculated based on fiscal year quarters or months.
- Re-enrollment is automatic.

6.3 Disenrollment

- Prime enrollees, other than active duty, may disenroll at any time.
- Regional contractors may deny re-enrollment (lockout) for 12 months following the disenrollment date to the following Prime enrollees (other than active duty):
    - ADFMs of sponsors who are E-5 and above, who change their enrollment status (i.e., from enrolled to disenrolled or vice versa) more than twice in an enrollment year for any reason.

- Those who voluntarily disenroll before the annual enrollment renewal date (1 October).
- Those who fail to pay required enrollment fees during an enrollment period.
- The 12-month lockout provision does not apply to ADFMs whose sponsor's pay grade is E-1 through E-4.

6.4 The Role of the Primary Care Manager

The PCM is a TRICARE-authorized civilian network provider or military treatment facility provider who gives primary care services. A PCM is assigned to the Prime enrollee and is responsible for:

- Providing all non-emergency health care, including urgent care
- Submitting referrals for specialty care
- Establishing medical necessity when required

6.5 Prime Costs

- There are no costs for TRICARE-covered health care services provided to ADSMs and their Prime-enrolled family members, as long as non-emergency/routine care is received from their assigned primary care manager (PCM) and referrals and authorizations for specialty care is in place.
- If a Prime enrollee, including an ADSM, gets care without the proper authorization, TRICARE may deny the claim.
- There may be cost shares associated with pharmacy benefits. For pharmacy costs and information please see the *Pharmacy* module.

Status	**ADFM E1–E4**	**ADFM E5 and Up**	**Retirees/Family Members, Eligible Former Spouses, and Survivors**
Enrollment Fee	$0	$0	$230 individual or $460 per family (if enrolled prior to October 1, 2011, for FY 2012) After October 1, 2011: $260 individual or $520 per family
Copayments	$0	$0	$12 per outpatient visit $17 per outpatient mental health group visit $20 per outpatient ambulance svc occurrence $25 per mental health individual visit $30 per emergency room visit
Deductibles	N/A	N/A	N/A
Catastrophic Cap	$1,000 per family per fiscal year	$1,000 per family per fiscal year	$3,000 per family per fiscal year
Civilian Inpatient Cost Share	$0 per admission	$0 per admission	$11 per day or $25 per admission, whichever is greater; no charge for separately billed professional charges
Civilian Inpatient Mental Health	$0 per admission	$0 per admission	$40 per day; no charge for separately billed professional charges

6.6 Point of Service Option (POS)

The Point of Service (POS) option allows non-active duty TRICARE Prime enrollees to receive non-emergency care from any TRICARE-authorized provider without a referral from their PCM. Prime enrollees pay higher out-of-pocket costs to use this option. POS has its own deductible. Any out-of-pocket expenses paid under POS do not apply to the annual catastrophic cap.

6.6.1 POS Costs

POS Charges	Individual	Family
Deductible Per Fiscal Year	$300	$600
Cost Shares for Outpatient Claims	50% of TRICARE allowable charge after POS deductible is met	
Cost Shares for Inpatient Claims	50% of TRICARE allowable charge	
50% cost share applies even after the catastrophic cap for the enrollment/fiscal year is met.		

6.6.2 POS Does Not Apply in the Following Circumstances:

- Emergency department services
- Preventive care services from a network provider
- The initial eight behavioral health outpatient visits from a network provider.
- When the Prime enrollee has other health insurance (OHI), which acts as his/her primary payer.
- Prime/Prime Remote newborn or adoptee care during the initial 60 days (120 days overseas) when they are deemed Prime (see Section 10.1, *Newborn Coverage*).
- If an ADSM gets care without the proper authorization, TRICARE may deny the claim.

6.6.2.1 POS Example

A TRICARE Prime ADFM was treated by a TRICARE-authorized provider for medically necessary, TRICARE-covered specialty care. The family member sought care on his/her own without a referral from his/her PCM.

The provider usually charges $1,000.00 for this type of appointment. TRICARE's allowable charge is $850.00.

Remember, under point of service the beneficiary must pay the POS deductible and a 50% cost share before TRICARE cost sharing can begin.

6.6.2.2 POS Illustration

Provider Billing	**Cost**
TRICARE-authorized provider's charge	$1,000.00
TRICARE Allowable Charge	$850.00
POS deductible (individual rate)	$300.00
Balance	$550.00
Settling the Payment	**Cost**
Balance	$550.00
Beneficiary pays 50% cost share	$275.00 (50% of $550)
Remaining balance to be paid by TRICARE	$275.00
Beneficiary's total out-of-pocket cost	$575.00 ($300 deductible + $275 cost share)

6.7 Obtaining Emergency Care

- For emergency care, Prime enrollees should go to the nearest emergency room.
- Prime enrollees are required to notify their PCM or regional contractor within 24 hours of receiving emergency care and/or being admitted to an inpatient facility.
- Tell Prime enrollees to get a copy of the emergency treatment records in case proof is needed of emergency care given. Please note that a claim may be denied if the diagnosis does not warrant emergency care.

7.0 Referrals for Specialty Care

When Prime enrollees need specialty care their PCM cannot provide, the PCM writes a referral. It is the enrollee's responsibility to make sure the referral is authorized by the regional contractor before scheduling the specialty appointment.

7.1 Getting the Referral Authorized

Getting the referral authorized is a multi-step process:

- The PCM submits the referral electronically or via fax to the regional contractor.
  - Beneficiaries may receive a written referral from the PCM and take it to the TRICARE Service Center for processing.
  - It takes at least 48 hours for the referral to be entered into the regional contractor's system.
  - Beneficiaries may call the regional contractor's toll-free number three to five days after the referral is entered to check on the authorization before scheduling their appointment.
- The regional contractor sends a letter to the enrollee with the name(s) of a network specialty care provider and the referral authorization, including the number and types of visits authorized.
- The Prime enrollee must contact the specialty provider(s) listed on the authorization letter to confirm appointment availability or call the regional contractor to request a change to the identified specialist.
- Before scheduling the appointment, the enrollee should try to get copies of information the specialty provider may need (e.g., x-rays, lab results).
- MTF Prime enrollees must find out what the MTF's policy is for transferring medical records, x-rays, etc. to the specialty care provider.
- Prime enrollees should take their PCM's or regional contractor's phone number to their specialty appointment in case there are questions.

8.0 TRICARE Prime Portability

TRICARE Prime is portable. This means that when Prime-enrolled beneficiaries move to a new location where Prime is offered, they may continue TRICARE Prime without a break in coverage.

- Enrollees must transfer their enrollment to the new regional contractor and select a new PCM to avoid point of service charges and a potential interruption of coverage
- Prime enrollees may complete both enrollment transfer and PCM selection by: calling the losing contractor, using the Beneficiary Web Enrollment (BWE) web site at dmdc.osd.mil/appj/bwe, for other than active duty, or by visiting a TRICARE Service Center upon arrival at the new location. These methods can also be used to transfer between Prime and Prime Remote, stateside and overseas.

8.1 Transferring Prime Within the Same Region

- Enrollees should update their address in DEERS and notify the regional contractor of their address change.
- They request a PCM change in the new location by submitting a new *TRICARE Prime Enrollment Application and PCM Change Form* (DD Form 2876),contacting the regional contractor, entering info in the BWE web site, or dropping it off at the TRICARE Service Center.

8.2 Transferring Prime To a Different Region

- When relocating from one region to another, Prime enrollees should not disenroll from their current region before leaving their location. Remaining enrolled to the current region ensures they avoid an interruption in TRICARE Prime coverage.
- Enrollees must get referrals from their PCM and authorization from their current regional contractor before getting non-emergency, specialty, or inpatient care while en route to the new location to avoid point of service charges.
- Enrollment transfers are effective on the date the gaining regional contractor processes the signed enrollment form. The gaining regional contractor assigns a new PCM to the enrollee, provides region- or site-specific TRICARE educational materials, and key telephone numbers.

8.3 Transfer Frequency

- Prime-enrolled retirees and their eligible family members who move from one region to another and back to the original region are allowed two enrollment transfers per enrollment year.
    - The number of moves within the same region per enrollment year is unlimited; beneficiaries must ensure address changes are updated in DEERS
    - When transferring from one region to another before the annual enrollment renewal, all future enrollment fees are billed by and paid to the gaining regional contractor.
- If the enrollee transfers to an area where Prime is not offered, the unused portion of the enrollment fee may not be refunded. If enrollees anticipate moving to an area where Prime is not available, they should consider paying the enrollment fee on a quarterly or monthly basis.

8.4 Transferring to a Non-Prime Location:

- Enrollees are covered by TRICARE Prime while en route to the non-Prime region.
- Enrollees must update their address in DEERS to confirm their move.
- Upon arrival in a non-Prime Service Area, enrollees should update their address in DEERS and call the regional contractor or go the BWE web site to disenroll from Prime.
- Beneficiaries may request a waiver to TRICARE Prime access standards to remain enrolled in Prime, even if they moved to a location outside of a Prime Service Area
    - If approved, enrollees then travel a longer distance to see their assigned PCM and network speciality providers. Enrollees must still follow TRICARE Prime rules (PCM for routine care, referrals and authorizations required).
    - TRICARE Prime access standard waiver approval is not guaranteed.

8.5 Split Prime Enrollment Between Different TRICARE Regions

- TRICARE Prime split enrollment offers families the option to enroll one or some members in Prime in one region while the rest of the family lives and remains enrolled in another Prime region.
- The sponsor or legal guardian must complete and sign an enrollment form for the affected family member(s) and submit it to the regional contractor where the other family member(s) lives.
- The family may pay one enrollment fee to whichever regional contractor is chosen by the family to serve as the home region; enrollment fees are applied to all family members and payment is recorded in DEERS, if applicable.

9.0 Additional Health Care Prime Enrollee Benefits

9.1 Newborn Coverage

9.1.1 Stateside Coverage

- By policy, a newborn child is covered under TRICARE Prime and TRICARE Prime Remote for Active Duty Family Members (TPRADFM) for 60 days after birth, as long as one additional family member is already enrolled in either of these programs or the sponsor is enrolled in TRICARE Prime Remote (TPR).
- After the initial 60 days, any claim submitted for a newborn processes as TRICARE Standard until the newborn is registered in DEERS and enrolled in TRICARE Prime.
- TRICARE eligibility ends after 365 days for any newborn who is not registered in DEERS.

9.1.2 Overseas Coverage

- Although a newborn child is covered under TRICARE Overseas Program (TOP) Prime and TOP Prime Remote for 60 days after birth as long as one additional family member is already enrolled in either of these

programs, the TRICARE Area Office director may extend the deemed enrollment period for the newborn up to 120 days on a case-by-case or regional basis.

- After the initial 120 days, any claim submitted for a newborn processes as a TOP Standard claim until the newborn is registered in DEERS and enrolled in TOP Prime or TOP Prime Remote.
- TRICARE eligibility ends 365 days after the birth of any newborn who is not registered in DEERS.
- Sponsors should contact the nearest consulate or embassy to confirm U.S. citizenship and to obtain a Consular Report of Live Birth.

9.2 Pre-Adoptive and Adopted Children

9.2.1 Stateside Coverage

- Pre-adoptive and adopted children must be registered in DEERS as soon as possible. If the child is not registered in DEERS, he/she cannot show as TRICARE eligible.
- Once registered, pre-adoptive children are covered under TRICARE Prime or TPRADFM for 60 days, as long as another family member is enrolled in a Prime option, beginning on the date of placement by the court or approved adoption agency.
- To continue Prime coverage beyond the first 60 days, the pre-adoptive/adopted child must be enrolled in either TRICARE Prime or TPRADFM within the 60-day time frame.
- If the child is not enrolled in a Prime option after the initial 60 days, any claim submitted processes as TRICARE Standard.

9.2.3 Overseas Coverage for Adoptees

- Have to be registered in DEERS to show as TRICARE eligible.
- Just as with a newborn, a waiver is in place to extend the Prime enrollment time frame for adoptees from 60 to 120 days for TRICARE Overseas Program (TOP) Prime and TOP Prime Remote enrollees.
- After the initial 120 days, any claim submitted for the adoptee processes as TOP Standard until the adoptee is registered in DEERS and enrolled in TOP Prime/TOP Prime Remote.

10.0 The TRICARE Prime Travel Benefit

- When stateside-enrolled non-active duty TRICARE Prime and TPRADFM enrollees are referred for medically necessary, non-emergency specialty care more than 100 miles from their assigned primary care manager's location, they may be eligible for the TRICARE Prime travel benefit, meaning they may be reimbursed for reasonable travel expenses.
- The "greater than 100 mile rule" is statutory and is not negotiable when determining applicability of the Prime travel benefit.
- Active duty travel for medical care is handled through their service personnel and medical assets.

10.1 General Process for Receiving Travel Reimbursement

- When the MTF Prime enrollee is referred for specialty care over 100 miles away from the PCM or civilian TRICARE-authorized provider's location, before traveling he/she should contact the MTF point of contact for information on the reimbursement process.
- When the civilian PCM-assigned Prime enrollee is referred by a civilian PCM, before traveling he/she should contact a Prime travel benefit point of contact at the TRICARE Regional Office (TRO).
    - Beneficiaries must obtain official travel orders from the MTF or TRO point of contact and are required to make their own travel arrangements.
    - Beneficiaries must coordinate their own lodging arrangements.
    - After the medical travel is complete, the expenses must be itemized on a SF 1164 or a DD Form 1351-2

(*travel voucher*).

- Receipts are required for all expenses.
- The MTF or TRO point of contact provides the beneficiary with specific instructions on how and where to submit their travel reimbursement claim.

- Travel claims are processed using the Defense Travel System (DTS). For DoD-employees traveling in temporary duty or temporary assignment status travel authorizations are entered into the DTS and routed through the traveler's employer or command for approval.

10.2 Reasonable Travel Expenses

- Reasonable travel expenses are the actual costs incurred by the Prime/TPRADFM enrollee when traveling to their specialty provider in a non-emergency status. Costs include meals, gas, tolls, parking, and tickets for public transportation (e.g., airplane, train, bus, etc.).
- Enrollees are required to submit receipts for all expenses.
  - Government rates will be used to estimate the reasonable cost.
  - Enrollees are expected to use the least expensive form of transportation.

The actual costs of lodging (including taxes and tips) and the actual cost of meals (including taxes and tips, but excluding alcoholic beverages) may be reimbursed up to the government rate for the area where the enrollee is getting speciality care.

10.3 Traveling with a Non-Medical Attendant

The non-medical attendant must be a parent, legal guardian, an adult family member or a companion who has been granted a medical Power of Attorney by the enrollee or legally responsible party. The non-medical attendant is authorized to receive reimbursement of reasonable travel expenses.

- If the non-medical attendant family member is an active duty service member authorized by the military treatment facility or TRICARE Regional Office to accompany a non-active duty TRICARE Prime enrollee as a non-medical attendant, he/she is entitled to temporary duty/temporary additional duty (TDY/TAD) allowances (per diem and mileage), not actual expenses. TDY/TAD status is managed through service channels.
- If the non-medical attendant family member is a U.S. Government civilian assigned to TDY/TAD by their civilian organization, they may be entitled to TDY/TAD allowances.
- When the non-medical attendant is not the parent, he/she must be at least 21 years old.
- The non-medical attendant is not required to be enrolled in TRICARE Prime or to be TRICARE eligible.
- Non-medical attendants who qualify for reimbursement under this entitlement should save their travel receipts.
- For more information about the TRICARE Prime travel entitlement, please contact the local MTF, TRO Prime Travel Benefit point of contact, or go to tricare.mil/mybenefit/BenefitUpdates.jsp?fid=545 for more information.

11.0 TRICARE Travel Benefit for Those with a Combat-Related Special Compensation (CRSC) Determination

Certain retirees who were awarded Combat-Related Special Compensation may be entitled to the CRSC travel benefit. This provides these select retirees reimbursement for travel-related expenses when they must travel more than 100 miles from their referring provider's location to obtain medically necessary, non-emergency specialty care for a documented combat-related condition. This travel benefit is not available overseas. A written referral from their primary care provider is required.

11.1 Eligibility for Travel Reimbursement under Combat-Related Special Compensation

The retiree must:

- Not be enrolled in TRICARE Prime or with a designated provider (US Family Health Plan)**and**
- Be entitled to retired or retainer pay; **and**
- Have been determined by their service to have a CRSC condition; **and**
- Have a referral for care of a condition related to the CRSC determination; **and**
- Have a need to travel more than 100 miles from the referring provider's office to get the needed specialty care.

11.2 Request for Reimbursement

Before traveling, retirees who qualify for the special compensation travel reimbursement benefit should mail or fax the following to their TRICARE Regional Office (check each TROs web site for contact information):

- A copy of the service's CRSC determination letter along with the referral for care associated with the condition mentioned in the determination letter;
- A completed direct deposit form (required only on initial travel request); **and**,
- If another adult must accompany the retiree, reimbursement is available and a direct deposit slip is also required for that individual. This need must be determined by the provider currently involved in the retiree's care, and documentation to support the need must be submitted.

11.3 Receiving Reimbursement

- After the specialty care appointment, the retiree must submit the following documentation to their TRO to receive reimbursement:
    - Completed reimbursement forms (DD 1351-2, DD 1351-3 or SF 1164.)
    - Travel receipts
    - A copy of a statement from the provider or other document that indicates the retiree completed their appointment(s) for the special compensation condition.
- After the TRO receives all the necessary documents, the TRO submits approved claims to the Defense Finance and Accounting Service (DFAS) for payment.

Module Objectives

Summary

- **Explain the differences between TRICARE Standard, Extra, and Prime**
- **Identify TRICARE-authorized provider types**
- **Explain the TRICARE costs associated with the basic TRICARE options**
- **Describe the TRICARE Prime travel benefit and the reimbursement process**